Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NORTH TEXAS REHAB CENTER

Respondent Name
NORTH RIVER INSURANCE CO

MFDR Tracking Number
M4-14-2291-02

Carrier's Austin Representative
Box Number 53

MFDR Date Received
March 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has denied this claim originally on May 17, 2013 and reconsideration July 16, 2013 for the dates of service March 27, thru April 9, 2103. The sessions of chronic pain management were pre-authorized on March 26, 2013, a copy is attached... We request MDR to order the carrier to pay for the medical services."

Amount in Dispute: $28,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier denied payment for the dates of service based on an extent of injury dispute. Attached please find the Carrier's PLNs-11 filed February 28, 2013 and March 27, 2013. These extent of injury disputed have not been adjudicated, therefore, it does not appear that medical review division has jurisdiction to adjudicate these dates of service at this time."

Response Submitted by: Hoffman Kelley, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2013 through April 9, 2013	97799-CP-CA x 10 days	$28,000.00	$9,750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Medical Fee Guideline for Workers' Compensation Specific Services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216 – Based on the findings of a review organization
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Issues

1. Did the insurance carrier raise the issue of extent of injury during the bill review process?
2. Did the requestor obtain preauthorization for the disputed chronic pain management services?
3. Is the requestor entitled to reimbursement?

Findings

1. The division finds that the extent-of-injury and related disputes are decided through the Texas Labor Code Chapter 410 and 28 Texas Administrative Code Chapters 140 through 144 dispute resolution processes. To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Texas Administrative Code §133.240(e), (e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified: Former 133.240(e), (e)(1), (2)(C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division .... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with §124.2 of this title ,... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

   The division reviewed the explanation of benefits provided in the dispute and determined that the disputed services were not denied for extent of injury during the bill review process. As a result, the division will address only those denial reasons raised on the explanation of benefits presented to Medical Fee Dispute Resolution.
2. Per 28 Texas Administrative Code §134.600(p) states in relevant part, "Non-emergency health care requiring preauthorization includes:.. (10) chronic pain management/interdisciplinary pain rehabilitation."

   The requestor submitted a copy of a preauthorization letter dated March 26, 2013 issued by GENEX, authorizing 10 sessions of a chronic pain management program with a start date of March 22, 2013 through June 21, 2013. Review of the submitted documentation finds that the requestor seeks resolution for chronic pain management services rendered March 27, 2013 through April 9, 2013, 10 sessions of chronic pain management. The Division finds that the disputed charges were preauthorized and therefore, the Division will review the disputed charges per the applicable guidelines.
3. 28 Texas Administrative Code §134.204(h) states "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier."

   28 Texas Administrative Code §134.204(h)(1)(A), states, "Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   Review of the CMS-1500's document that the requestor billed for CPT code 97799-CP-CA indicating that a CARF accredited chronic pain management program was rendered.

   28 Texas Administrative Code §134.204 (h)(5) states, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

   Review of the submitted documentation finds that the requestor billed and documented 8 hours of chronic pain management for dates of service March 27, March 28, March 29, April 1, April 2, April 3, April 4 and April 5; 8 hours x $125.00/hour = $1,000.00/day x 8 days = $8,000.00.

The requestor billed and documented 7 hours on April 8, 2013; and billed 8 hours on April 9, 2013, however documented 7 hours. Reimbursement is therefore recommended for 7 hours/day for April 8, 2013 and April 9, 2013; 7 hours x $125.00/hour = $875.00/day x 2 days = total of $1,750.00.

The requestor is therefore entitled to a total recommended reimbursement of $9,750.00 for dates of service March 27, 2013 through April 9, 2013.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $9,750.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 23, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.